Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

HARRIET JACOBS
50 LOCKES CORNER ROAD
ALTON NH 03809

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name:
PACIFIC INDEMNITY CO

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number:
M4-12-3157-01

MDFR Received Date

JUNE 20, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: A position summary was not submitted with the request for medical fee dispute resolution.

Amount in Dispute: $324.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Respondent's first receipt of the Claimant's request for reimbursement was a copy of the DWC-60 in this matter. Respondent, therefore, had to make a quick determination regarding this request in order to adequately respond to this dispute. For this reason, Respondent was not afforded the 45 days to pay or deny the request as allowed by DWC Rule 133.270. The services in dispute were not ordered by a physician. Instead, the services were ordered by the Claimant and her mother and were subsequently paid for by her mother. As all healthcare treatment must be at the direction of the treating doctor or a referral doctor, reimbursement for these services were denied as they were not ordered by a physician. Additionally, healthcare treatment does require preauthorization. The Claimant and/or her mother failed to obtain preauthorization for these services. Thus, reimbursement is denied. In conclusion, the denial of the reimbursement sought by the Claimant and her mother should be upheld.

Response Submitted by: Downs-Stanford, PC, 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 30, 2012 March 31, 2012 April 1, 2012	Caregiver Services	$234.00	0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured employees to submit workers' compensation out-of-pocket expenses to the insurance carrier for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - No EOBs submitted by either party.

Issues

1. Did the requestor submit the out-of-pocket expenses for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor submit documentation to support the disputed bills were submitted to the insurance carrier for reimbursement in accordance with 28 Texas Administrative Code §133.270(c)(4)(I)?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Texas Administrative Code §133.307(c)(1) the request for medical fee dispute resolution was filed timely.
2. In accordance with 28 Texas Administrative Code §133.270(c)(4)(I) a copy of the insurance carrier's or health care provider's denial of reimbursement or refund relevant to the dispute, or, if no denial was received, convincing evidence of the injured employee's or injured employee's mother's attempt to obtain reimbursement or refund from the insurance carrier or health care provider. Review of the submitted documentation does not include convincing evidence that the request for reimbursement was made. Therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 5, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.